# Filing at a Glance

| | |
|---|---|
| Company: | Investors Heritage Life Insurance Company |
| Product Name: | 2012 Applications |
| State: | Arkansas |
| TOI: | L08 Life - Other |
| Sub-TOI: | L08.000 Life - Other |
| Filing Type: | Form |
| Date Submitted: | 11/20/2012 |
| SERFF Tr Num: | IHLI-128746012 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | IHLIC 2012 APPLICATIONS |
| Implementation Date Requested: | On Approval |
| Author(s): | Julie Hunsinger, Karen Jones, Brad Shepherd |
| Reviewer(s): | Linda Bird (primary) |
| Disposition Date: | 11/29/2012 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

**State:** *Arkansas* **Filing Company:** *Investors Heritage Life Insurance Company*
**TOI/Sub-TOI:** *L08 Life - Other/L08.000 Life - Other*
**Product Name:** *2012 Applications*
**Project Name/Number:** *2012 Applications/*

## General Information

Project Name: 2012 Applications
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Karen Jones

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 10/29/2012
Domicile Status Comments: Forms have been filed in the state of Kentucky and are approved for use.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 11/29/2012
State Status Changed: 11/29/2012
Created By: Karen Jones
Corresponding Filing Tracking Number:

Filing Description:
We are submitting the attached application forms for your consideration for approval. The application forms were previously approved for use in the state of Arkansas, tracking and approval information is outlined on the Forms Schedule. The only changes made to these applications were the required MIB Language change.

## Company and Contact

### Filing Contact Information

Karen Jones, Filing Administrator
P.O. Box 717
Frankfort, KY 40602-0717

kjones@ihlic.com
800-422-2011 [Phone] 1007 [Ext]
502-875-7084 [FAX]

### Filing Company Information

Investors Heritage Life Insurance Company
P.O. Box 717
200 Capital Avenue
Frankfort, KY 40602-0717
(502) 209-1007 ext. [Phone]

CoCode: 64904
Group Code:
Group Name:
FEIN Number: 61-0574893

State of Domicile: Kentucky
Company Type: LAH
State ID Number:

## Filing Fees

Fee Required? Yes
Fee Amount: $200.00
Retaliatory? No
Fee Explanation: 4 application forms x $50 = $200.00
Per Company: No

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| Investors Heritage Life Insurance Company | $200.00 | 11/20/2012 | 65065703 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *IHLI-128746012* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IHLIC 2012 APPLICATIONS* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Investors Heritage Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *2012 Applications* | | |
| ***Project Name/Number:*** | *2012 Applications/* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Linda Bird | 11/29/2012 | 11/29/2012 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *IHLI-128746012* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IHLIC 2012 APPLICATIONS* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Investors Heritage Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *2012 Applications* | | |
| ***Project Name/Number:*** | *2012 Applications/* | | |

## Disposition

Disposition Date: 11/29/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | | Yes |
| **Supporting Document** | Application | | No |
| **Form** | Heritage Final Expense II Application | | Yes |
| **Form** | Whole Life Insurance Application | | Yes |
| **Form** | Whole Life Insurance Application | | Yes |
| **Form** | Heritage Advantage Application | | Yes |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *IHLI-128746012* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IHLIC 2012 APPLICATIONS* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Investors Heritage Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *2012 Applications* | | |
| ***Project Name/Number:*** | *2012 Applications/* | | |

# Form Schedule

**Lead Form Number: 28901 AR (REV 09-2012)**

| Item No. | Schedule Item Status | Form Name | Form Number | Form Type | Form Action | Action Specific Data | | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | Heritage Final Expense II Application | 28901 AR (REV 09-2012) | AEF | Revised | Previous Filing Number: | IHLI-125902009 | 50.500 | 28901 AR REV 09-2012-ltr.pdf |
| | | | | | | Replaced Form Number: | 28901 AR (10-2008) | | |
| 2 | | Whole Life Insurance Application | ICC09-24900 (REV 09-2012) | AEF | Revised | Previous Filing Number: | IHLI-126159482 | 50.300 | ICC24900 non-compact-newform#-LTR.pdf |
| | | | | | | Replaced Form Number: | ICC09-24900 (Rev. 04-2009) | | |
| 3 | | Whole Life Insurance Application | ICC10-PUR-APP | AEF | Revised | Previous Filing Number: | IHLI-126872052 | 50.300 | ICC10-PURAPP-NONCOMPACT.pdf |
| | | | | | | Replaced Form Number: | ICC10-PUR-REV (9-2010) | | |
| 4 | | Heritage Advantage Application | ICC11-AR-FEAPP | AEF | Revised | Previous Filing Number: | IHLI-126952001 | 51.200 | ICC11-AR-FEAPP (09-2012).pdf |
| | | | | | | Replaced Form Number: | ICC11-AR-FEAPP (1-2011) | | |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *IHLI-128746012* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IHLIC 2012 APPLICATIONS* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Investors Heritage Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *2012 Applications* | | |
| ***Project Name/Number:*** | *2012 Applications/* | | |

| | | | |
|---|---|---|---|
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

# INVESTORS HERITAGE
*Life Insurance Company*


# HERITAGE FINAL EXPENSE

# ARKANSAS

GUARANTEED POLICY VALUES
GUARANTEED PREMIUMS
CASH VALUE WHOLE LIFE INSURANCE

## PLAN 1 - FULL BENEFIT

Level death benefit to age 100, endowing for face amount at age 120.
Issue Ages 0 to 80
Minimum Face Amount: $2,000
Maximum Face Amount: $25,000 for ages 0-65; $15,000 for ages 66-80
Premium Payment Options: 5 pay, 10 Pay, 20 Pay, Pay to Age 100

**INVESTORS HERITAGE** *Life Insurance Company*
Post Office Box 717 Frankfort, Kentucky 40602-0717
Phone: 800-422-2011 Fax: 502-875-7084 E-Mail: ihlic@ihlic.com
Web Site: www.investorsheritage.com

28901 AR (REV 09-2012)

APPLICATION
FOR LIFE INSURANCE

**INVESTORS HERITAGE**
*Life Insurance Company*

P O Box 717 Frankfort, KY 40602-0717
Ph: 800.422.2011 Fax: 502.875.7084
E-mail:ihlic@ihlic.com www.investorsheritage.com

PRINT USING BLACK INK

## Section 1 — PROPOSED INSURED

| Name (First, Middle, Last) | Date of Birth Month | Day | Year | Age | Sex ❑Male ❑Female |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City, State, Zip |
|---|---|
| | |

| Height ft. in. | Weight lbs. | Home Phone ( ) | Other Phone ( ) | Best Time to Call ❑AM ❑PM |
|---|---|---|---|---|
| | | | | |

| Social Security Number | Driver's License Number / State of Issue | Has the proposed insured used tobacco in the past 12 months? ❑ Yes ❑ No |
|---|---|---|
| | | |

## Section 2 — OWNER (if different from Proposed Insured)

| Name (First, Middle, Last) | Relationship to Proposed Insured |
|---|---|
| | |

| Street Address | City, State, Zip |
|---|---|
| | |

| Social Security Number | Home Phone ( ) | Other Phone ( ) | Best Time to Call ❑AM ❑PM |
|---|---|---|---|
| | | | |

## Section 3 — BENEFICIARY INFORMATION

| Primary Beneficiary Name (First, Middle, Last) | Social Security or Tax ID Number | Relationship to Proposed Insured |
|---|---|---|
| | | |
| Contingent Beneficiary Name (First, Middle, Last) | Social Security or Tax ID Number | Relationship to Proposed Insured |
| | | |

If there is to be more than one Primary and / or Contingent Beneficiary, please list on a separate sheet the names, social security numbers and relationships to the Proposed Insured.

## Section 4 — POLICY INFORMATION

| Premium Payment Period | Premium Payment Frequency | Face Amount of Insurance |
|---|---|---|
| ❑ 5 Yrs ❑ 10 Yrs<br>❑ 20 Yrs ❑ To Age 100 | ❑ Annually ❑ Semi-Annually ❑ Quarterly<br>❑ Monthly ❑ Monthly PAT ❑ Payroll Deduction | $ |

| **Does the Proposed Insured have any existing life insurance policies or annuity contracts? If "Yes", complete replacement form. ..... ❑ Yes ❑ No** | Premium Paid to Agent $ |
|---|---|

## Section 5 — HEALTH QUESTIONS

1. Within the past 90 days, have you been bedridden at home, confined in a hospital, nursing home, or long-term care faciilty, used oxygen equipment to assist in breathing, or received hospice care? ..... ❑Yes ❑No
2. To the best of your knowledge, have you ever been diagnosed by a member of the medical profession as having, or have you been tested positive for, or been treated by a member of the medial profession, for any of the following: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ..... ❑Yes ❑No
3. Within the past 5 years, have you been diagnosed or treated by a member of the medical profession for, or are you taking medication for, any of the following:
   a. Heart disease or disorder, heart attack, stroke, chest pain, heart surgery, angioplasty, congestive heart failure, or high blood pressure (except high blood pressure controlled with medication)? ..... ❑Yes ❑No
   b. Diabetes and high blood pressure together, diabetes that required insulin injections prior to age 50, or any complication of diabetes, including amputation, numbness, eye or kidney disorder, coma or insulin shock? ..... ❑Yes ❑No
   c. Cancer of any organ, melanoma, leukemia, kidney failure or dialysis, liver disease or cirrhosis, chronic lung disease, or tuberculosis? ..... ❑Yes ❑No
   d. Alzheimer's Disease, Down's Syndrome, Lou Gehrig's Disease (ALS), Multiple Sclerosis (MS), Parkinson's Disease, Systemic Lupus Erthemotosus (SLE), or seizure disorder? ..... ❑Yes ❑No
4. Within the past 5 years, have you been arrested, received two or more citations for moving traffic violations, or been convicted of driving under the influence of alcohol or drugs? ..... ❑Yes ❑No
5. Within the past 10 years, have you received treatment or counseling for the use of alcohol, or the use or possession of any narcotic, stimulant, sedative, or hallucinogenic drug? ..... ❑Yes ❑No

Primary Care Physician's Name, Address and Phone Number

# HERITAGE FINAL EXPENSE

## NOTICE OF INFORMATION PRACTICES

This Notice must be given to applicant at time of application. This Notice is not part of the application.

INSURANCE INFORMATION PRACTICES. We will rely primarily on the information you give to us. We may also get information from other sources, such as doctors or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

MIB PRE-NOTICE. Information regarding your insurability will be treated as confidential. Investors Heritage Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL HISTORY INTERVIEW. We may conduct a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the information on the application is correct. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to help determine your eligibility for insurance.

CONTESTABILITY. You are strongly urged to review the completed application for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

YOUR RIGHTS TO ACCESS AND CORRECTION. You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

FRAUD NOTICES:

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits.

## PREMIUM RECEIPT

Make check or money orders payable to Investors Heritage.
Do not make checks or money orders payable to the agent or leave the payee blank.

Amount Received: $_____ From: _____ Date: _____
month day year

This premium was paid in connection with an application for life insurance. The insurance applied for shall not take effect until payment of the first full premium, approval by Investors Heritage Life Insurance Company, delivery of the policy while the health condition of the Proposed Insured and other factors affecting insurability are as stated in the application, all of which must occur during the lifetime of the insured. In the event the application is declined, any payment made by the applicant will be returned.

_____
Agent's Signature

_____ _____
Agent's Phone Number Agent's Address

## AGREEMENT & MEDICAL AUTHORIZATION

I have read, or had read to me, the above questions and my answers to them. To the best of my knowledge and belief, my answers are complete, true, and accurate. All questions were asked of me.

I understand that Investors Heritage Life Insurance Company, hereafter called "Company", does not give any agent or person other than an officer of the Company authority to waive any answer or otherwise modify this application.

Medical Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc., or other organization, institution, or person, that has any record or knowledge of any proposed insured's health, to give to Company or its representative or its reinsurers any such information. I understand that the information will be used to determine a Proposed Insured's eligibility for insurance. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program. A copy of this authorization shall be as valid as the original. This authorization is valid for 24 months from the date signed. My authorized representative or I may request a copy of this authorization, and I can revoke this authorization by written notice to the Company.

## FRAUD NOTICES

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and denial of insurance benefits.

## INSURED'S / OWNER'S STATEMENT

This application has been completed in my presence and all questions have been asked by the agent and answered to the best of my knowledge and belief. I understand that a specially trained interviewer from the Investors Heritage home office may call to verify information given on the application.

Signature of proposed insured

City and state where application signed

Signature of owner if different than proposed insured

Date

## AGENT'S STATEMENT

I, the undersigned agent, certify:

(1) I have seen the proposed insured have witnessed the signature of the applicant and the proposed insured, if different.
(2) I have asked all questions and truly and accurately recorded the answers contained herein.
(3) The applicant / proposed insured is either personally known to me or I have seen their government issued identification.

Does the proposed insured have any existing life insurance or annuities? If "Yes", complete replacement form. ❑**Yes** ❑**No**

| Signature of licensed agent 1 | Agent Code # | Printed name of licensed agent 1 |
|---|---|---|
| Signature of licensed agent 2 | Agent Code # | Printed name of licensed agent 2 |

## REQUEST FOR PREAUTHORIZED TRANSFER PLAN (PAT)

I hereby request and authorize Investors Heritage Life Insurance Company, Frankfort, Kentucky ("Investors Heritage") to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for this policy. This authorization shall be subject to the following conditions:

(1) The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified;
(2) Investors Heritage shall not incur any liability on any transfer returned by the bank;
(3) Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;
(4) This authorization may be revoked by either party upon 30 days advance written notice, and Investors Heritage may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Frequency of Transfer — Renewal premiums will be debited on MONTHLY mode unless a different mode is marked.

☐ ANNUALLY ☐ SEMI-ANNUALLY ☐ QUARTERLY ☐ MONTHLY

| Date | Depositor's Printed Name as it appears on bank records | Depositor's Signature |
|---|---|---|

| Name of Bank | Bank or branch address |
|---|---|

Complete the following OR submit a voided check.

Account Type:
☐ Checking
☐ Savings

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Routing Number ☐☐☐☐☐☐☐☐☐

APPLICATION
FOR LIFE INSURANCE

**INVESTORS HERITAGE** *Life Insurance Company*
PO Box 717 ▪ Frankfort, KY 40602-0717 ▪ Phone: 800.422.2011 ▪ Fax: 502.875.7084
E-mail: investorsheritage@ihlic.com ▪ www.investorsheritage.com

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

## SECTION 1 — PROPOSED INSURED

| 1. Name (First, Middle, Last) | | 2. Birth Date Month / Day / Year | 3. State/Country of Birth |
|---|---|---|---|
| 4. Street Address | | 5. ☐ Male ☐ Female | 6. Citizenship (Country) |
| 7. City, State, Zip | | 8. Home Phone ( ) | 9. Other Phone ( ) |
| 10. Social Security Number | 11. Employer Name & Address | 12. Occupation & Duties | |
| 13. E-mail Address | | 14. Driver's License Number/State of Issue | |

## SECTION 2 — OWNER (If different from Proposed Insured)

| 1. Name (First, Middle, Last) | 2. Home Phone ( ) | 3. Other Phone ( ) |
|---|---|---|
| 4. Mailing Address | 5. Birth Date Month / Day / Year | 6. E-mail Address |
| 7. Relationship to Proposed Insured | 8. Social Security Number or Tax ID Number | |

## SECTION 3 — BENEFICIARY

| | SSN | Relationship to Proposed Insured | Share % if not equal |
|---|---|---|---|
| 1. Primary Beneficiary Name(s) | | | |
| 2. Contingent Beneficiary Name(s) | | | |

## SECTION 4 — THE POLICY

1. Choose Plan of insurance ☐ Whole Life ☐ Term

1a. If term plan, years of insurance _____

1b. Insurance Face Amounts/Units & Annual Premium

2. Benefits (If available )
Mark appropriate box and indicate Face Amount or Premium

| | Face Amount / Units | Annual Premium |
|---|---|---|
| 2a. ☐ Additional Insured Rider (If yes, complete AIR Application) | 2a. | 2a. |
| 2b. ☐ Child Rider (If yes, complete CR application) | 2b. | 2b. |
| 2c. ☐ Accidental Death Benefit Rider on Primary Insured (Maximum Issue Amount—$150,000) | 2c. | 2c. |
| 2d. ☐ Waiver of Premium Rider on Primary Insured | 2d. | 2d. |
| 2e. ☐ Other Rider _____ | 2e. | 2e. |
| | Policy Fee | $ |
| | Total Annual Premium | $ |

1b. Face Amount / Units: 1b. _____ Annual Premium: 1b. _____

3. Automatic Premium Loan Option? ☐ Yes ☐ No

4. Cash with application
$ _____

5. Premium Period
☐ 5 Pay ☐ 10 Pay
☐ 20 Pay ☐ To Age 65
☐ To Age 100

5. Payment mode
☐ Annual
☐ Semi-Annual
☐ Quarterly PAT
☐ Monthly PAT

6. Planned modal premium
$ _____

## SECTION 5 — OTHER INSURANCE / REPLACEMENT INFORMATION

1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life)
(a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application?
❑Yes ❑No Provide details to "Yes" answers below and submit appropriate replacement forms.

| 2. Name of Company | Date of Issue | Life Amount | Personal/Business | Accidental Death Amount | To be replaced? |
|---|---|---|---|---|---|
| | | | ☐ Personal ☐ Business | | ☐ Yes ☐ No |
| | | | ☐ Personal ☐ Business | | ☐ Yes ☐ No |
| | | | ☐ Personal ☐ Business | | ☐ Yes ☐ No |
| | | | ☐ Personal ☐ Business | | ☐ Yes ☐ No |
| | | | ☐ Personal ☐ Business | | ☐ Yes ☐ No |

If there is additional insurance beyond those listed, please provide on a separate sheet of paper.

SECTION 6

## GENERAL RISK INFORMATION

1. In the past 3 years, has the Proposed Insured used tobacco or products containing nicotine? ☐ Yes ☐ No

| If yes, check all that apply. | ☐Cigarettes | ☐Cigar | ☐Pipe | ☐Chewing Tobacco | ☐Snuff | ☐Nicotine Substitutes |
|---|---|---|---|---|---|---|
| Date first used (month/year) | | | | | | |
| Date last used (month/year) | | | | | | |
| Quantity | | | | | | |

2. Within the past 5 years, has the Proposed Insured:
   a. Plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; plead guilty to or been convicted of any moving violation; or been involved in any accident in which the Proposed Insured was found to be at fault? ☐ Yes ☐ No
   b. Flown, other than as a fare paying passenger on a scheduled airline, or intend to do so within the next 2 years? (If "Yes", complete an Aviation Questionnaire) ☐ Yes ☐ No
   c. Participated in motor sports events or racing, boat racing, rock or mountain climbing, hang gliding, ballooning, sky diving or scuba diving or intend to do so within the next 2 years? (If "Yes", complete an Avocation Questionnaire) ☐ Yes ☐ No
   d. Plead guilty to or been convicted of any felony or misdemeanor, or have any misdemeanor or felony charge currently pending? (If "Yes" provide details including state, county, and city of violations.) ☐ Yes ☐ No
3. Is the Proposed Insured a member of the military, military reserve, or National Guard, whether active or inactive; or has the Proposed Insured entered into a written agreement to become a member of the military, military reserve, or National Guard, whether active or inactive, at a future date? (If "Yes", complete a Military Service Questionnaire) ☐ Yes ☐ No
4. Has the Proposed Insured ever had life, health, or disability insurance declined, postponed, modified or rated? ☐ Yes ☐ No (If "Yes", provide details including company name, date issued, amount, owner and if business or personal.)
5. Within the past 12 months, has the Proposed Insured been unable to work, attend school, been unable to perform normal daily activities, or been confined at home? ☐ Yes ☐ No

SECTION 7

## MEDICAL INFORMATION

1. Name and address of usual medical advisor(s) _____
2. Date of last visit: _____ 3. Reason for last visit: _____
4. What treatment was given or medication prescribed? _____
5. Height: _____ ft _____ in. 6. Weight: _____ lbs. 7. Weight change in past year? ☐ Gain ☐ Loss ☐ No Change 8. Cause of weight change: _____
9. Within the past 10 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:
   a. High blood pressure, stroke, chest pain, coronary artery disease or any other disease of the heart, blood vessels, cerebrovascular system, or cardiovascular system? ☐ Yes ☐ No
   b. Cancer, tumor, leukemia, lymphatic cancer or any other growth or malignancy? ☐ Yes ☐ No
   c. Diabetes, thyroid disorder, anemia or any blood or glandular disorder? ☐ Yes ☐ No
   d. Asthma, shortness of breath, sleep apnea, or any other nose, throat, lung, or respiratory disorder? ☐ Yes ☐ No
   e. Any disorder of the stomach, intestines, liver or pancreas, including hepatitis, ulcers or any other disorder of the digestive system? ☐ Yes ☐ No
   f. Any injury or disease of the bones, muscles, joints, eyes or skin? ☐ Yes ☐ No
   g. Epilepsy, seizures, brain disorder, or any other disease of the nervous system? ☐ Yes ☐ No
   h. Anxiety, depression, or an emotional, behavioral, mental or nervous disorder? ☐ Yes ☐ No
   i. Any disease or disorder of the kidney, bladder or reproductive system? ☐ Yes ☐ No
10. Within the past 10 years, has the Proposed Insured used or experimented with barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician? ☐ Yes ☐ No
11. Within the past 10 years, has the Proposed Insured received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No
12. Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
13. Other than stated above, within the past 5 years has the Proposed Insured been treated, examined or advised by a member of the medical profession to get any specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? ☐ Yes ☐ No
14. Have the Proposed Insured's parents and / or siblings been diagnosed or treated for heart disease, kidney disease, diabetes, cancer or stroke? (If "Yes", indicate family member, illness, age at onset of illness, and if applicable, age at death.) ☐ Yes ☐ No

Explanation of all "Yes" answers in Sections 6 & 7. Use additional paper or continue in Special Requests Section, if necessary.

| Number | Illness | Date & Duration | Treatment & Results | Doctors & Hospitals |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SPECIAL REQUESTS / REMARKS

## FRAUD NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

## PREMIUM PAYOR (if different than Proposed Insured)

| 1. Name (First, Middle, Last) | 2. Home Phone ( ) | 3. Social Security Number |
|---|---|---|
| 4. Mailing Address | 5. City, State Zip | 6. Relationship to Proposed Insured |

## REQUEST FOR PRE-AUTHORIZED TRANSFER (PAT)

I hereby request and authorize Investors Heritage Life Insurance Company, Frankfort, Kentucky ("Investors Heritage") to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for this policy. This authorization shall be subject to the following conditions:

(1) The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified;

(2) Investors Heritage shall not incur any liability on any transfer returned by the bank;

(3) Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;

(4) This authorization may be revoked by either party upon 30 days advance written notice, and Investors Heritage may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Frequency of Transfer

☐ ANNUALLY ☐ SEMI-ANNUALLY ☐ QUARTERLY ☐ MONTHLY

Renewal premiums will be debited on MONTHLY mode unless a different mode is marked.

Date _____ Depositor's Printed Name as it appears on bank records _____ Depositor's Signature _____

Name of Bank _____ Bank or branch address _____

Complete the following OR submit a voided check.

Account Type:

☐ Checking
☐ Savings

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Routing Number ☐☐☐☐☐☐☐☐☐

The 28th is the last day of the month that a pre-authorized transfer can be made.

## TAX CERTIFICATION

Under penalties of perjury, it is certified that (a) the Social Security number(s) or Tax ID number(s) shown in this application are correct, and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax for failure to report interest or dividends.

## ACKNOWLEDGEMENT

I, the Proposed Insured (and any Owner signing below), ACKNOWLEDGE that I have been given a copy of the "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and also a copy of the MIB Pre-Notice. I know that this application cannot be processed if I do not sign the authorization below.

## AGREEMENT

I, the Proposed Insured (and any Owner signing below) AGREE to the following:

a. Have read or had read to me the application and all statements and answers in this application as they pertain to me are complete and true to the best of my knowledge and belief.
b. Insurance will start only as provided in the Conditional Receipt. If no Conditional Receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all proposed insureds is not as described in the application.
c. Investors Heritage Life Insurance Company, hereinafter called "Insurance Company", does not give any agent or person other than an officer of the Insurance Company authority to waive any answer or otherwise modify this application.
d. $ _____ has been deposited toward payment of the first premium on the applied for policy. The terms of the Conditional Receipt for that premium deposit are accepted.

## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned declares that:

a. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for the Insurance Company to determine its obligations under the policy issued in connection with this application.
b. The Insurance Company, its reinsurers, insurance support organizations, consumer reporting agencies and their authorized entities may obtain data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information.
c. Any doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, MIB, Inc.. viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company which has such data about me may give such data to the Insurance Company and its reinsurers when this authorization or a copy of it is shown. All sources but MIB may give such data to agencies that the Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) , may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Authorization is signed.
d. Any request by the Insurance Company for medical records is on my behalf and the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
e. Data about mental illness, alcoholism, sexually transmitted diseases and the use of drugs are to be included, except for psychotherapy notes.
f. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.
g. This authorization is good for 24 months after it is signed.
h. The Insurance Company may obtain an investigative consumer report ("inspection report") on me.
   ☐ Yes, I want to be interviewed if such a report is obtained.
i. I have read this authorization and know my authorized representative or I may request a copy of it. I may revoke this authorization by writing to the Insurance Company.

## SIGNATURES OF PROPOSED INSURED / OWNER

X) _____ Signed at _____ On _____

Signature of Proposed Insured if age 18 or older (15 or older in Kentucky and North Carolina) — (City, State) — (Month, Day, Year)

X) _____

Signature of Owner if other than Proposed Insured

X) _____

Signature of parent or guardian if Proposed Insured age 17 or younger (14 or younger in Kentucky and North Carolina)

## AGENT'S STATEMENT AND SIGNATURE

I, the undersigned agent(s), certify that:

1. The applicant is either personally known to me or I have seen the applicant's government issued identification;
2. I have witnessed the signature of the applicant and/or any proposed insured;
3. I have asked each proposed insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of any proposed insured which is not fully recorded in this application.
4. Does the Proposed Insured now have any life insurance or annuity in force with any company? ☐ Yes ☐ No
   If "Yes" complete and submit the appropriate replacement forms.

Date: _____

X) _____ _____ _____

Signature of licensed agent 1 — IHLIC Agent Code # — Name of licensed agent or representative (Please Print)

X) _____ _____ _____

Signature of licensed agent 2 — IHLIC Agent Code # — Name of licensed agent or representative (Please Print)

# INVESTORS HERITAGE *Life Insurance Company*

## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| Proposed Insured / Patient | Date of Birth Month | Day | Year | Social Security Number |
|---|---|---|---|---|
| Proposed Additional Insured | Month | Day | Year | |
| Children Proposed for Insurance | Month | Day | Year | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose my entire medical record, medication history, and any other protected health information concerning me to Investors Heritage Life Insurance Company, or its designee.

Name of designee (if applicable) _____

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Investors Heritage Life Insurance Company may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Investors Heritage Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Investors Heritage Life Insurance Company, P.O. Box 717, Frankfort, KY 40602, Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization or to the extent that Investors Heritage Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, Investors Heritage Life Insurance Company will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Investors Heritage Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that my authorized representative or I am entitled to a copy of this signed authorization.

Date: _____

X) _____

Signature of Primary Proposed Insured / patient or personal representative

X) _____

Signature of Additional Proposed Insured / patient or personal representative

# AGENT'S REPORT

## SECTION 1 — EXAM INFORMATION

1. If required, have you ordered or obtained: ☐ Exam ☐ Blood Profile ☐ Urine Specimen ☐ Other _____

2. Name of paramedical company or examiner _____

3. Date scheduled or completed _____

## SECTION 2 — PROPOSED INSURED INFORMATION

1. Contact Proposed Insured(s) at: ☐ Home ☐ Business ☐ Other

   Telephone number ( ) _____

2. Best day(s) to contact Proposed Insured(s) ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

3. Best time to contact Proposed Insured(s) ☐ 9 am - 12 pm ☐ 1 pm - 4 pm ☐ 5 pm - 8:30 pm

4. How long have you known the Proposed Insured? _____ ☐ Friend ☐ Relative ☐ Just Met ☐ Existing Client ☐ Acquaintance

5. Proposed Insured's annual income? _____

6. Proposed Insured's net worth? _____

7. Did you personally interview the Proposed Insured(s) and complete the application in his or her presence? ☐ Yes ☐ No

8. Prior residence address if current is less than 5 years?

   _____

   _____

## SECTION 3 — AGENT CHECKLIST

Explain all "Yes" answers in Section 6 - Agent Remarks / Explanations.

1. Do you know anything not disclosed which affects the underwriting of this risk? ☐ Yes ☐ No
2. Is there another application currently pending or being submitted to any other life insurance company? ☐ Yes ☐ No
3. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months? ☐ Yes ☐ No

## SECTION 4 — PROPOSED INSURED UNDER AGE 18 OR FOR CHILD RIDER

Explain all "No" answers in Section 6 - Agent Remarks / Explanations.

1. Did you see the child(ren) proposed for insurance? ☐ Yes ☐ No
2. Do all the children proposed for insurance appear to be in good health? ☐ Yes ☐ No
3. Are all brothers and sisters insured for equal amounts? ☐ Yes ☐ No
4. Are the parents insured for at least as much as that applied for and in force on the child? ☐ Yes ☐ No

## SECTION 5 — PURPOSE OF INSURANCE

☐ Family security ☐ Business loan ☐ Buy-sell agreement

☐ Key Person ☐ Personal loan or residential mortgage ☐ Other _____

## SECTION 6 — AGENT REMARKS / EXPLANATIONS TO ANSWERS ABOVE

## SECTION 7 — AGENT CERTIFICATION

I certify that

1. I have asked each question separately, the answers were recorded as given, and they are complete and accurate to the best of my knowledge and belief;
2. I have complied with state and federal laws on disclosure, cost comparison and replacement; and
3. I have given the applicant a copy of the Notice of Information Practices.

Date: _____

X) _____ _____ _____

Signature of licensed agent 1 | IHLIC Agent Code # | Name of licensed agent or representative (Please Print)

X) _____ _____ _____

Signature of licensed agent 2 | IHLIC Agent Code # | Name of licensed agent or representative (Please Print)

INVESTORS HERITAGE LIFE INSURANCE COMPANY
PO Box 717
Frankfort, KY 40602-0717
800.422.2011

## CONDITIONAL INSURANCE RECEIPT

This Conditional Receipt provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this receipt. This Conditional Receipt may not be given if the age of any proposed insured is under 15 days or over 70 years of age.

AMOUNT LIMITATION

The maximum amount of life insurance, including accidental death, which will become effective under this receipt will be the smaller of the face amount of insurance applied for or $100,000. This includes any pending and in force insurance.

CONDITIONS

1. A minimum advance payment equal to one month's premium for the insurance applied for must be made.
2. Any check given in payment must be honored when first presented to the bank.
3. All medical examinations and tests required by the Company's initial underwriting requirements must be completed and received at our Home Office during the lifetime of any individual proposed for insurance, and prior to the Company's termination of the application, but in any case within sixty (60) days from the completion of the application.
4. If any person proposed for insurance dies by suicide or if the application contains any material misrepresentations, then the Company's liability under this receipt is limited to a refund of the premium paid.
5. Each person proposed for insurance must be a risk insurable on the application date in accordance with the Company's rules, limits and standards for the plan and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.



INVESTORS HERITAGE LIFE INSURANCE COMPANY
PO Box 717
Frankfort, KY 40602-0717
800.422.2011

## NOTICE OF INFORMATION PRACTICES

*THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED*


### INFORMATION INSURANCE PRACTICES

We will rely primarily on the information you give to us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

### MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Investors Heritage Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

### FAIR CREDIT REPORTING ACT
### INVESTIGATIVE CONSUMER REPORTS

In compliance with the Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. Information may be obtained through personal interviews with neighbors, friends, associates or other persons with whom you are acquainted. This inquiry includes information as to the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You have the right to make a written request to Investors Heritage Life Insurance within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

INVESTORS HERITAGE LIFE INSURANCE COMPANY

CONDITIONAL INSURANCE RECEIPT (continued from front)

BEGINNING DATE. If all conditions in this receipt have been fulfilled exactly, coverage under the policy applied for, subject to the Amount Limitations, may begin on the later of:

1. The date of completion of the application;
2. The date of completion of all medical examinations, tests and other evidence required by the Company; or
3. The policy date, if any, requested in the application.

TERMINATION DATE. Coverage under this receipt, if it has begun, will terminate automatically on the earliest of (1) sixty days from the date of this receipt; or (2) the date the insurance takes effect under the applied for policy.

If the policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first full premium must be paid. If the application is declined or not approved within sixty (60) days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. THIS RECEIPT IS NOT VALID UNLESS SIGNED BY A LICENSED AGENT OF INVESTORS HERITAGE LIFE INSURANCE COMPANY.

Amount Received: $_____ From: _____ Date: _____
month day year

Agent's Signature _____

Agent's Address _____

Agent's Phone Number _____

ICC09-24900 (REV 09-2012) CONDITIONAL RECEIPT

NOTICE OF INFORMATION PRACTICES (continued)

## PERSONAL HISTORY INTERVIEW

We may also conduct a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the information regarding the insured on the application is correct. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to help determine your eligibility for insurance.

## MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests include a paramedical exam, which will consist of questions about your medical history and measurement of your body height, weight, blood pressure, and pulse. Blood tests, and in some instances, an EKG (electrocardiogram) may be required. If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

## CONTESTABILITY

You are strongly urged to review the completed application for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

## YOUR RIGHTS TO ACCESS AND CORRECTION

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

## FRAUD NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

## INVESTORS HERITAGE LIFE INSURANCE COMPANY

INVESTORS HERITAGE LIFE INSURANCE COMPANY
200 CAPITAL AVENUE
PO BOX 717
FRANKFORT KY 40602-0717

PHONE: 800.422.2011
FAX: 502.875.7084
EMAIL: ihlic@ihlic.com
WEBSITE: www.investorsheritage.com

APPLICATION FOR
INDIVIDUAL LIFE INSURANCE AND ANNUITY

**INVESTORS HERITAGE** *Life Insurance Company*
PO Box 717 ▪ Frankfort, KY 40602-0717 ▪ Phone: 800.422.2011 ▪ Fax: 502.875.7084
E-mail: investorsheritage@ihlic.com ▪ www.investorsheritage.com

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

## 1. PROPOSED INSURED / PROPOSED ANNUITANT

Name (First, Middle Initial, Last)

| Birth Date Month | Day | Year | State/Country of Birth | ☐ Male ☐ Female | Height: ft. | in. | Weight: lbs. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Primary Mailing Address | City | State | Zip Code

Social Security Number | E-mail Address

Phone Number ( ) ☐ Home ☐ Work ☐ Mobile

Phone Number ( ) ☐ Home ☐ Work ☐ Mobile

## 2. SECONDARY ADDRESSEE

(Provide name and mailing address of person to receive grace and lapse notification on behalf of the Proposed Insured.)

Secondary Addressee Name (First, Middle Initial, Last)

Mailing Address | City | State | Zip Code

## 3. BENEFICIARY INFORMATION

| | | | |
|---|---|---|---|
| Primary Beneficiary Name (First, Middle Initial, Last) | Social Security Number | % Benefit if not equal | Relationship to Proposed Insured |
| Contingent Beneficiary Name (First, Middle Initial, Last) | Social Security Number | % Benefit if not equal | Relationship to Proposed Insured |

## 4. OWNER (If other than Proposed Insured / Annuitant)

Name (First, Middle Initial, Last) | Birth Date Month | Day | Year

Social Security Number | Relationship to Proposed Insured | Phone Number ( ) ☐ Home ☐ Work ☐ Mobile

Mailing Address | City | State | Zip Code | E-mail Address

## 5. INSURANCE AND ANNUITY INFORMATION

Mark plans applying for:

☐ Single Premium Whole Life Insurance — Face Amount $_____

☐ 10 Pay Whole Life Insurance — Face Amount $_____

☐ Single Premium Immediate Annuity ☐ Qualified ☐ Non-Qualified — Single Premium $_____

Annual payments for 10 years or until the annuitant's death, whichever is earlier.
*SPIA only available with the 10 Pay Whole Life Insurance.*

Premium Submitted with application $_____

## 6. RIDER INFORMATION

Mark riders applying for:

☐ Accelerated Death Benefit Rider ☐ Yes ☐ No Automatically included unless "NO" is marked.

☐ Other _____

## 7. HEALTH INFORMATION

If any question in this section is answered "Yes", no coverage can be issued.
If height & weight exceeds the maximum allowed for this product, no coverage can be issued.

1. Do you need assistance with the normal activities of daily living (eating, bathing, dressing, taking medications, etc.) or are you currently hospitalized, confined to a bed or nursing facility or receiving hospice care? ..... ☐ Yes ☐ No

2. Have you been diagnosed with Diabetes prior to age 20 or taken insulin injections prior to age 40? Have you ever been treated for insulin shock, diabetic coma or hospitalized two or more times for diabetic complications within the last 18 months? ..... ☐ Yes ☐ No

3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? ..... ☐ Yes ☐ No

4. Have you had or been medically advised to have an organ transplant, hospice care, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months? ..... ☐ Yes ☐ No

5. Have you ever been medically diagnosed, treated or taken medication for: congestive heart disease, cardiomyopathy, end stage kidney (renal) disease, kidney (renal) insufficiency, chronic kidney disease (including dialysis), kidney or liver failure, Alzheimer's disease, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or brain disease? ..... ☐ Yes ☐ No

6. In the last 5 years have you been convicted of a felony or are you currently on probation, been treated or advised by a medical professional to have treatment for alcohol, drugs or medication abuse? ..... ☐ Yes ☐ No

7. Within the past 3 years have you been diagnosed with leukemia, lymphoma, melanoma or internal cancer or have you had more than one occurrence of any cancer in your lifetime (excluding basal or squamous cell skin cancer), had a recurrence of any cancer, or are you currently being treated for cancer, had an amputation caused by cancer or an amputation caused by any disease? ..... ☐ Yes ☐ No

8. Within the past 2 years have you:

   a. Been medically diagnosed, treated or taken medication for: angina, chronic hepatitis, cirrhosis, liver disease, Hodgkin's disease, chronic obstructive pulmonary or lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, or required oxygen to assist in breathing? ..... ☐ Yes ☐ No

   b. Been diagnosed as having, been treated for or hospitalized for: heart disease, heart attack, peripheral vascular disease, heart or vascular surgery (including coronary artery bypass, angioplasty, stent placement (cardio or vascular), pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve circulation to the heart, brain or extremities, neuromuscular disease (including multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's disease), systematic lupus (SLE) or paralysis of two or more extremities? ..... ☐ Yes ☐ No

   c. Been medically diagnosed, treated or taken medication for stroke, transient ischemic attack (TIA), or been diagnosed as having uncontrolled high blood pressure? ..... ☐ Yes ☐ No

   d. Been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or hospice care? ..... ☐ Yes ☐ No

   e. Been convicted of operating a motor vehicle while intoxicated, impaired or reckless driving? ..... ☐ Yes ☐ No

   f. Been declined or postponed for life or health insurance? ..... ☐ Yes ☐ No

   g. Attempted suicide? ..... ☐ Yes ☐ No

## 8. ADDITIONAL INFORMATION

| Proposed Insured's Driver's License Number | State of Issue |
|---|---|
| | |

1. Have you used nicotine or tobacco based products in the past 12 months? ..... ☐ Yes ☐ No
2. Have you applied for life insurance with any other company in the past two years? ..... ☐ Yes ☐ No
3. Are you taking medication for any impairment listed in Section 7 Health Information? ..... ☐ Yes ☐ No

## 9. OTHER INSURANCE / REPLACEMENT INFORMATION

1. Does Proposed Insured now have any life insurance or annuity (includes personal, business or group life)
(a) in force or applications pending with any company? or (b) which will be replaced, changed, or borrowed against because of this application?
☐Yes ☐No Provide details to "Yes" answers below and submit appropriate replacement forms.

| 2. Name of Company | Date of Issue | Life Amount | Personal/Business | Accidental Death Amount | To be replaced? |
|---|---|---|---|---|---|
| | | | ☐Personal ☐Business | | ☐ Yes ☐ No |
| | | | ☐Personal ☐Business | | ☐ Yes ☐ No |
| | | | ☐Personal ☐Business | | ☐ Yes ☐ No |
| | | | ☐Personal ☐Business | | ☐ Yes ☐ No |
| | | | ☐Personal ☐Business | | ☐ Yes ☐ No |

If there is additional insurance beyond those listed, please provide on a separate sheet of paper.

## 10. AGREEMENT & AUTHORIZATION

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Investors Heritage Life Insurance Company ("the Company") and the initial premium has been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer or any other person or organization that has any record of information about me to give Investors Heritage Life Insurance Company, its reinsurers or its authorized representatives, information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs, alcoholism, or other information Investors Heritage Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above, except MIB, Inc., to give such information to a consumer reporting agency acting on behalf of Investors Heritage Life Insurance Company. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice or revocation may be sent, in writing, to the Company at its administrative office address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

## 11. SIGNATURES OF PROPOSED INSURED / OWNER

X)_____
Signature of Proposed Insured

X)_____
Signature of Owner if other than Proposed Insured

Signed at_____
(City, State)

On _____
(Month, Day, Year)

## 12. AGENT'S STATEMENT AND SIGNATURE

To the best of my knowledge and belief the Proposed Insured and / or Owner ☐ does ☐ does not have any existing life insurance or annuity coverage and the life insurance applied for ☐ will ☐ will not replace any existing life insurance or annuity coverage.

I certify that I have verified the personal information of the applicant(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.

I certify that the Owner, Proposed Insured or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or any other secondary market.

Purpose of Insurance _____

I further certify that all questions on the application were asked and any information recorded by me on this application is true and accurate to the best of my knowledge and that I witnessed the signing of the application by the Owner and Proposed Insured who appeared to me to be lucid and able to fully understand all of the questions on this application.

This application signed and dated at _____ (City), _____ (State).

X) _____ _____
Licensed Agent's Signature — Date

_____ _____ _____
Agent's Printed Name — Agent's Code Number — Agent's Phone Number

X) _____ _____
Second Licensed Agent's Signature — Date

_____ _____ _____
Agent's Printed Name — Agent's Code Number — Agent's Phone Number

APPLICATION FOR
INDIVIDUAL LIFE INSURANCE

PRINT USING BLACK INK. ALL SECTIONS MUST BE COMPLETED.

**INVESTORS HERITAGE** *Life Insurance Company*
PO Box 717 ▪ Frankfort, KY 40602-0717 ▪ Phone: 800.422.2011 ▪ Fax: 502.875.7084
E-mail: ihlic@ihlic.com ▪ www.investorsheritage.com

## 1. PROPOSED INSURED

Name (First, Middle Initial, Last)

| Birth Date Month | Day | Year | State/Country of Birth | ☐ Male ☐ Female | Height: ft. | in. | Weight: lbs. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Primary Mailing Address | City | State | Zip Code

Social Security Number | E-mail Address

Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile | Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile | Best Time To Call ☐ AM ☐ PM | Time Zone

Physician's Name | Phone Number Including Area Code

## 2. BENEFICIARY INFORMATION

| Primary Beneficiary Name (First, Middle Initial, Last) | Social Security Number | % Benefit if not equal | Relationship to Proposed Insured |
|---|---|---|---|
| Contingent Beneficiary Name (First, Middle Initial, Last) | Social Security Number | % Benefit if not equal | Relationship to Proposed Insured |

## 3. OWNER (If other than Proposed Insured)

Name (First, Middle Initial, Last) | Birth Date Month | Day | Year

Social Security Number | Relationship to Proposed Insured | Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile

Mailing Address | City | State | Zip Code | E-mail Address

## 4. SECONDARY ADDRESSEE

Name (First, Middle Initial, Last) | Phone Number Including Area Code ☐ Home ☐ Work ☐ Mobile

Mailing Address | City | State | Zip Code

## 5. GENERAL INFORMATION

1. Have you used tobacco products or products containing nicotine in the past 12 months? ..... ☐ YES ☐ NO
2. Are you currently receiving disability payments? If "Yes", indicate reason: _____ ☐ YES ☐ NO
3. Have you ever plead guilty to or been convicted of a felony? ..... ☐ YES ☐ NO
4. Within the past 24 months, have you received three or more citations for moving traffic violations or been convicted of driving under the influence of alcohol or drugs? ..... ☐ YES ☐ NO

## 6A. HEALTH INFORMATION

1. Do you need assistance performing any activities of daily living such as eating, bathing, dressing, or toileting or are you currently hospitalized or confined to a wheelchair, bed, or nursing facility? ..... ☐ YES ☐ NO
2. Have you been diagnosed by a member of the medical profession or tested positive for Acquired Immune Deficiency Syndrome (AIDS Virus) or Human Immunodeficiency Virus (HIV)? ..... ☐ YES ☐ NO
3. Have you been diagnosed by a member of the medical profession as having a terminal illness or a life expectancy of 12 months or less, Alzheimer's Disease or dementia, or congestive heart failure (CHF), or have you had a heart, lung, or liver transplant or has one been recommended to you? ..... ☐ YES ☐ NO
4. Are you currently receiving kidney dialysis or using oxygen to assist in breathing, or have you been advised by a member of the medical profession to have any medical test (except those tests related to the Human Immunodeficiency Virus (AIDS virus)), hospital or nursing facility confinement, or psychiatric or home health care and not done so? ..... ☐ YES ☐ NO

If all health questions 1-4 are answered "NO", proceed to Section 6B on the next page.
If you answered any question "YES", you do not qualify for coverage.

## 6B. HEALTH INFORMATION

1. During the past 24 months, have you had, been treated or diagnosed by a member of the medical profession or taken prescription medications for alcohol or drug abuse, internal cancer, Leukemia, or Melanoma (excluding basal/squamous cell skin cancers)? ☐ YES ☐ NO
2. During the past 12 months have you been diagnosed by a member of the medical profession as having a brain tumor, heart attack, stroke, transient ischemic attack (TIA), or have you been treated for or been advised by a member of the medical profession to have brain, heart or circulatory surgery? ☐ YES ☐ NO
3. During the past 24 months have you been treated by a member of the medical profession for insulin shock, diabetic coma, amputation caused by disease, or have you taken insulin shots prior to age 40? ☐ YES ☐ NO

## 6C. HEALTH INFORMATION

1. During the past 12 months, have you been admitted to or confined in a hospital two or more times? ☐ YES ☐ NO
2. During the past 24 months, have you been diagnosed with, been treated for, or had a member of the medical profession recommend treatment (including office visits, medications, or surgery) for :
   a. Parkinson's disease, seizures, depression or neurological disorders? ☐ YES ☐ NO
   b. Stroke, transient ischemic attack (TIA), heart attack, angina, irregular heartbeat, or any procedure to improve circulation to the heart or brain? ☐ YES ☐ NO
   c. Liver disease, renal insufficiency, kidney transplant, or kidney failure? ☐ YES ☐ NO
   d. Diabetes with uncontrolled blood pressure, diabetes requiring more than 60 units of insulin daily, or any complication of diabetes including amputation, numbness, eye or kidney disorder, coma or insulin shock, or uncontrolled blood sugars? ☐ YES ☐ NO
   e. Emphysema, chronic bronchitis, chronic asthma, Chronic Obstructive Pulmonary Disease (COPD) or black lung? ☐ YES ☐ NO
3. During the past 36 months have you had a member of the medical profession diagnose, treat, prescribe medication, or recommend treatment (including office visits, inpatient treatment, medications, or surgery) for alcohol or drug abuse, internal cancer, Leukemia or melanoma? ☐ YES ☐ NO

## 7. POLICY INFORMATION

Plan of Insurance
☐ Full
☐ Graded
☐ Reduced

ADB Rider ☐ Yes ☐ No

Premium Payment Period
☐ 5 Years ☐ 10 Years
☐ 20 Years ☐ Whole Life

Premium Payment Frequency
☐ Annually ☐ Quarterly
☐ Monthly PAT ☐ Semi-Annually
☐ Special Payment Option

Face Amount of Insurance $ _____

Premium Amount $ _____

Does the Proposed Insured have any existing life insurance or annuity contracts inforce? ☐ YES ☐ NO
Will the Proposed Insured replace or change any life insurance or annuity contract in force because of this application? ☐ YES ☐ NO
If "Yes" to either question, complete replacement form as appropriate to state in which application is signed.

## 8. REQUEST FOR PREAUTHORIZED TRANSFER

I hereby request and authorize Investors Heritage Life Insurance Company, Frankfort, Kentucky ("Investors Heritage") to make preauthorized transfers from my bank account by way of draft, check, or electronic transfer for the payment of premiums for this policy. This authorization shall be subject to the following conditions:

1. The preauthorized transfer shall occur on or after the premium due dates unless otherwise specified;
2. Investors Heritage shall not incur any liability on any transfer returned by the bank;
3. Amounts not honored by the bank after initial deposit shall constitute non-payment of premium and coverage shall lapse subject to all provisions of each policy;
4. This authorization may be revoked by either party upon 30 days advance written notice, and Investors Heritage may immediately revoke this request if any preauthorized transfer is dishonored by the bank when presented.

Frequency of Transfer Renewal premiums will be debited on MONTHLY mode unless a different mode is marked.

☐ ANNUALLY ☐ SEMI-ANNUALLY ☐ QUARTERLY ☐ MONTHLY Draft Date Requested _____

Date _____ Depositor's Printed Name as it appears on bank records _____ Depositor's Signature _____

Name of Bank _____ Bank Branch or Address _____

Complete the following OR submit a voided check.

Account Type:
☐ Checking
☐ Savings

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Routing Number ☐☐☐☐☐☐☐☐☐

## 9. PREMIUM PAYOR (If different than owner)

| Name (First, Middle Initial, Last) | Social Security Number | Phone # with Area Code ☐ Home ☐ Work ☐ Mobile |
|---|---|---|
| Mailing Address City State Zip | | Relationship to Proposed Insured |

## 10. AGREEMENT & AUTHORIZATION

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by Investors Heritage Life Insurance Company ("the Company") and the initial premium has been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy's incontestability provision. I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer or any other person or organization that has any record of information about me to give Investors Heritage Life Insurance Company, its reinsurers or its authorized representatives, information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs, alcoholism, or other information Investors Heritage Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above, except MIB, to give such information to a consumer reporting agency acting on behalf of Investors Heritage Life Insurance Company. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice or revocation may be sent, in writing, to the Company at its administrative office address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

## 11. SIGNATURES OF PROPOSED INSURED / OWNER

X) _____ X) _____

Signature of Proposed Insured | Signature of Owner if other than Proposed Insured

Signed at _____ On _____

(City, State) | (Month, Day, Year)

## 12. AGENT'S STATEMENT AND SIGNATURE

To the best of my knowledge and belief the Proposed Insured and / or Owner ☐ does ☐ does not have any existing life insurance or annuity coverage and the life insurance applied for ☐ will ☐ will not replace any existing life insurance or annuity coverage.

I certify that I have verified the personal information of the applicant(s) by viewing a state issued driver's license, state issued I.D. card, military I.D. card, Permanent U.S. Resident Card (Green Card), passport or other government issued picture I.D. card.

I certify that the Owner, Proposed Insured or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement or any other secondary market.

Purpose of Insurance _____

I further certify that all questions on the application were asked and any information recorded by me on this application is true and accurate to the best of my knowledge and that I witnessed the signing of the application by the Owner and Proposed Insured who appeared to me to be lucid and able to fully understand all of the questions on this application.

Mail policy to: ☐ Policyowner ☐ Agent

This application signed and dated at _____ _____

City | State

X) _____ _____

Licensed Agent's Signature | Date

_____ _____ _____

Agent's Printed Name | Agent's Code Number | Agent's Phone Number

X) _____ _____

Second Licensed Agent's Signature | Date

_____ _____ _____

Agent's Printed Name | Agent's Code Number | Agent's Phone Number

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INVESTORS HERITAGE LIFE INSURANCE COMPANY
PO Box 717
Frankfort, KY 40602-0717
800.422.2011

## CONDITIONAL INSURANCE RECEIPT

This Conditional Receipt provides a limited amount of life insurance coverage, for a limited period of time, subject to the terms of this receipt. This Conditional Receipt may not be given if the age of any proposed insured is under 15 days or over 70 years of age.

AMOUNT LIMITATION

The maximum amount of life insurance, including accidental death, which will become effective under this receipt will be the smaller of the face amount of insurance applied for or $30,000. This includes any pending and in force insurance.

CONDITIONS

1. A minimum advance payment equal to one month's premium for the insurance applied for must be made.
2. Any check given in payment must be honored when first presented to the bank.
3. All medical examinations and tests required by the Company's initial underwriting requirements must be completed and received at our Home Office during the lifetime of any individual proposed for insurance, and prior to the Company's termination of the application, but in any case within sixty (60) days from the completion of the application.
4. If any person proposed for insurance dies by suicide or if the application contains any material misrepresentations, then the Company's liability under this receipt is limited to a refund of the premium paid.
5. Each person proposed for insurance must be a risk insurable on the application date in accordance with the Company's rules, limits and standards for the plan and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid.

## NOTICE OF INFORMATION PRACTICES

*This Notice Must Be Given To Proposed Insured*

### INFORMATION INSURANCE PRACTICES

We will rely primarily on the information you give to us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

### MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Investors Heritage Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

### FAIR CREDIT REPORTING ACT
### INVESTIGATIVE CONSUMER REPORTS

In compliance with the Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. Information may be obtained through personal interviews with neighbors, friends, associates or other persons with whom you are acquainted. This inquiry includes information as to the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You have the right to make a written request to Investors Heritage Life Insurance within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

INVESTORS HERITAGE LIFE INSURANCE COMPANY

## CONDITIONAL INSURANCE RECEIPT (continued from front)

BEGINNING DATE. If all conditions in this receipt have been fulfilled exactly, coverage under the policy applied for, subject to the Amount Limitations, may begin on the later of:

1. The date of completion of the application;
2. The date of completion of all medical examinations, tests and other evidence required by the Company; or
3. The policy date, if any, requested in the application.

TERMINATION DATE. Coverage under this receipt, if it has begun, will terminate automatically on the earliest of (1) sixty days from the date of this receipt; or (2) the date the insurance takes effect under the applied for policy.

If the policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first full premium must be paid. If the application is declined or not approved within sixty (60) days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. THIS RECEIPT IS NOT VALID UNLESS SIGNED BY A LICENSED AGENT OF INVESTORS HERITAGE LIFE INSURANCE COMPANY.

Amount Received: $_____ From: _____ Date: _____
month day year

Agent's Signature _____ Agent's Address _____

Agent's Phone Number _____

## NOTICE OF INFORMATION PRACTICES (continued from front)

### PERSONAL HISTORY INTERVIEW

We will conduct a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the information regarding the insured on the application is correct. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to help determine your eligibility for insurance.

### CONTESTABILITY

You are strongly urged to review the completed application for accuracy. A claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost or denied.

### YOUR RIGHTS TO ACCESS AND CORRECTION

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

### FRAUD NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

### INVESTORS HERITAGE LIFE INSURANCE COMPANY

*Doorway to Your Heritage*

INVESTORS HERITAGE LIFE INSURANCE COMPANY
200 Capital Avenue Post Office Box 717
Frankfort, KY 40602-0717
Phone: 800.422.2011 Fax: 502.875.7084
Email: ihlic@ihlic.com Web: www.investorsheritage.com

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *IHLI-128746012* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IHLIC 2012 APPLICATIONS* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Investors Heritage Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *2012 Applications* | | |
| ***Project Name/Number:*** | *2012 Applications/* | | |

# Supporting Document Schedules

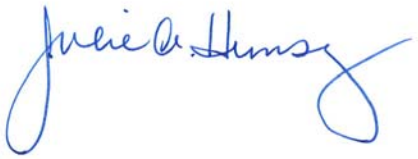
| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | see attached | | |
| Attachment(s): | | | |
| AR Readability Certification.pdf<br>AR Compliance Certifications.pdf | | | |

**APPLICATION FORMS FILING**
**READABILITY CERTIFICATION**

**INVESTORS HERITAGE LIFE INSURANCE COMPANY**
**NAIC No. 64904**

I have reviewed or supervised the preparation of the forms listed below and certify that the forms comply with the applicable readability requirements of the Arkansas Code.

| Form Number | Description | Flesch Score |
|---|---|---|
| 28901 AR (REV 09-2012) | Life Insurance Application | 50.5 |
| ICC09-24900 (Rev. 09-2012) | Life Insurance Application | 50.3 |
| ICC10-PUR-APP | Life Insurance Application | 50.3 |
| ICC11-AR-FEAPP | Life Insurance Application | 51.2 |



November 20, 2012_____
Date

Signature of President or designated representative

_____Julie Hunsinger, FSA, MAAA
Name of Person signing above

_____Vice President & Chief Actuary
Title of person signing above

INVESTORS HERITAGE *Life Insurance Company*
PO Box 717 Frankfort KY 40602-0717
1-800-422-2011
investorsheritage@ihlic.com

# Certificates of Compliance

Re: Form 28901 AR (REV 09-2012)
Form ICC09-2490 (Rev. 09-2012)
Form ICC10-PUR-APP
Form ICC11-AR-FEAPP

I hereby certify that the submitted forms listed above meet all applicable Arkansas requirements including the requirements of Rule and Regulation 19 and the requirements of Rule and Regulation 49.

I also hereby certify that the submitted forms listed above meet with the applicable readability requirements of the Arkansas Code.

Julie A. Hunsinger, FSA, MAAA
Vice President & Chief Actuary
November 12, 2012